CORONAVIRUS RELIEF FUND (CRF) GRANT APPLICATION
Assistance Program to Private Hospitals

APPLICANT INFORMATION

Hospital Name:

Tax Identification Number (TIN):

CMS Certification Number (CCN):

Fiscal Year End (Month):

FY2019 Gross Patient Revenue:

FY2019 Total Patient Days:

Street Address:

City:

Municipality:

Zip Code:

Contact Person Name:

Contact Person Title:

Telephone Number:

Email Address:

FUNDING INFORMATION

Has the Applicant **Received,** or does it **Anticipating Receiving,** any Funding Related to COVID-19?

Yes ☐ No ☐

If YES, list the source, amount, and (intended) use:

Amount ($)	Source	Use	Received (R) Anticipated (A)
			R ☐ A ☐
			R ☐ A ☐
			R ☐ A ☐
			R ☐ A ☐
			R ☐ A ☐
			R ☐ A ☐
			R ☐ A ☐
			R ☐ A ☐

*If more funding sources exist please use the table in Appendix A. The Applicant is required provide notice to the Grantor if this source of funds list changes during the Grant Period.

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Intended Use of Grant Funds:

Provide a list and brief description of how Applicant intends to use Grant Funds on eligible and necessary expenditures related to the COVID-19 emergency. This information is for Application evaluation purposes and may be modified by the Applicant to meet needs not identified at the time of Application, as long as the changes are consistent with the terms of the Grant. If the expense has not yet been incurred, please note it as "Anticipated" in the "Expense Date" column. If you have more expense line items than there is space below, please use the extended expense table in Appendix B **instead** of the table below. For further guidance please refer to the Guidance published by the U.S. Treasury at https://home.treasury.gov/policy-issues/cares/state-and-local-governments and the Frequently Asked Questions published by the U.S. Treasury at https://home.treasury.gov/system/files/136/Coronavirus-Relief-Fund-Frequently-Asked-Questions.pdf

Expense Date	Expense Description	Amount
	Total Funds Requested	$ 0

AUTHORIZED SIGNER INFORMATION

Authorized Signer Name:

Authorized Signer Title:

Telephone Number:

Email Address:

CERTIFICATIONS

Applicant hereby acknowledges and agrees that (please initial next to each statement):

_____ The Grant Funds requested are necessary due to the COVID-19 public health emergency.

_____ If Grant Funds cannot be used for qualifying expenses by December 30, 2020, they will be returned.

_____ Applicant shall submit any and all required documentation, and agree to any and all audits of the Grant Funds, as requested by Grantor.

_____ Any information provided in this application and other correspondence can become public information, and Applicant waives any right to confidentiality, unless expressly requested and approved.

_____ Applicant acknowledges a materially false, fictitious, or fraudulent statement (or concealment or omission of a material fact) in this certification, or in the application that it supports, may be the subject of criminal prosecution and also may subject me and the Applicant to civil penalties and/or administrative remedies for false claims or otherwise.

_____ I certify under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

SIGNATURE AND DATE

Signature: ______________________________

Date: ____________________

Appendix A: Extended Funding Table

Amount ($)	Source	Use	Received (R) Anticipated (A)
			R ☐ A ☐
			R ☐ A ☐
			R ☐ A ☐
			R ☐ A ☐
			R ☐ A ☐
			R ☐ A ☐
			R ☐ A ☐
			R ☐ A ☐
			R ☐ A ☐
			R ☐ A ☐
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			R ☐ A ☐
			R ☐ A ☐
			R ☐ A ☐
			R ☐ A ☐
			R ☐ A ☐
			R ☐ A ☐
			R ☐ A ☐
			R ☐ A ☐
			R ☐ A ☐
			R ☐ A ☐
			R ☐ A ☐

Appendix B: Extended Expense Table

Expense Date	Expense Description	Amount
	Total Funds Requested	$ 0